Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

M E M O R A N D U M

TO: Applicants for Athletic Trainer Certification

FROM: Sandy K. Brooks, Athletic Trainer Coordinator

RE: Certification as an Athletic Trainer

Enclosed is an application for certification as an athletic trainer in the Commonwealth of Kentucky. You are requested to complete the application, sign and have the form notarized. The completed application is to be returned in the envelope provided along with the following information:

- FORM 1: Verification of NATA certification. This should be sent directly to KBML from the NATA. (If applicable)
- Copy of current wallet card from the NATA. (If applicable)
- An official copy of college transcripts. This must be mailed directly to KBML from the college.
- FORM 2: Verification from an approved supervising athletic trainer showing completion of all training hours. This should be sent directly to KBML from the supervising athletic trainer.
- FORM 3: Verification from any state in which you currently hold or have ever held certification/licensure. This should be sent directly to KBML from any state in which you've been certified/licensed. (If applicable)
- A copy of a certificate of an HIV/AIDS education course that has been approved by the Kentucky Cabinet for Health Services.

Once the application has been received and is complete, it will be presented to the Kentucky Advisory Council on Athletic Trainers for their consideration. If the Council determines that you have met the statutory requirements for certification, your application will then be presented to the Kentucky Board of Medical Licensure for final approval.

For your information the fee for certification is:

- $25.00 certification fee
- $140.00 for state examination. The exam must be taken if you are not NATA certified. (This is the exam fee only, an additional $25.00 fee is due upon passing the exam. Exams are scheduled for June and December.)

Should you have any questions regarding the application, please contact me at (502) 429-8046.

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APPLICATION FOR ATHLETIC TRAINER CERTIFICATION IN KENTUCKY

(Please Type or Print)

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action. If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and provide an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your certification.

1. Name: _____

2. Address _____

3. City, State, Zip code _____

4. Social Security Number: _____ - _____ - _____

5. Phone: (home) _____ (work) _____

6. Place of Birth _____ Date of Birth _____

7. Current Place of Employment _____

   Employer's Address _____
   (street)

   _____
   (city) (state) (zip code)

8. NATA Certification # _____ Expiration Date _____

9. College/university from which you received your degree or required course work:

   Bachelors _____
   School Graduation Date Major/Minor

   Masters _____
   School Graduation Date Major

   Other _____
   School Graduation Date Major/Minor

Name _____Social Security Number_____

10. List <u>all</u> states in which you have applied for or been granted certification/license as an athletic trainer.

State	Certification #	Issue Date	Expiration Date

11. List all states in which you have applied for or been granted license/registration as a physical therapist.

State	Certification #	Issue Date	Expiration Date

12. Have you had any certificate, license, registration or other privilege to practice as a health care professional, denied, revoked, suspended, probated, or restricted by a State or Federal authority, or have you ever surrendered such credential to avoid or in connection with disciplinary investigation/action by such jurisdiction? ☐ YES ☐ NO

13. Have you been or are you currently under investigation by any State or Federal licensure authority or any drug licensure/enforcement authority? ☐ YES ☐ NO

14. Are any legal proceedings regarding certification/licensure presently pending against you by any State or Federal licensure authority or any drug licensure/enforcement authority? ☐ YES ☐ NO

15. Have you been convicted of a felony or misdemeanor by any State or Federal court? Are any criminal charges presently pending against you in any of those courts? ☐ YES ☐ NO

16. To your knowledge, are you the subject of an investigation for a criminal act? ☐ YES ☐ NO

17. Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Authority? ☐ YES ☐ NO

If you answered "<u>YES</u" to any of the above questions (#12 – 17), please attach a written explanation.

18. List the name and address of <u>every</u> athletic trainer that has supervised your work.

Trainer's Name	Location of Supervision (facility & full address)	Dates of Supervision
_____	_____	
_____	_____	_____ to _____
_____	_____	
_____	_____	_____ to _____
_____	_____	
_____	_____	_____ to _____
_____	_____	
_____	_____	_____to _____

***Name* _____*Social Security Number*_____**

19. I am applying for certification as an Athletic Trainer in Kentucky under the following criteria in accordance with KRS 311.916.

Check one

_____ Section 1(a): I have met the athletic training requirements by attending a **curriculum** college/university.

_____ Section 1(b): I hold a certificate or degree in **physical therapy** and have completed the following:

1. A basic athletic training course;
2. A first aid and a cardiopulmonary resuscitation course;
3. A nutrition course; and
4. Have spent a minimum of 600 clock hours working under the direct supervision of an approved athletic trainer.

_____ Section 1(c): I did not attend a curriculum college/university; however, I have completed at least four years beyond the secondary school level, while either an undergraduate or graduate student, and at this time I completed **four consecutive years of internship training** under the direct supervision of an approved athletic trainer.

AFFIDAVIT OF APPLICANT: I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board, or its agents, to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now, or in the future, have concerning my qualifications and fitness to practice as an athletic trainer to any person, institution, association, school, hospital or government entity. I understand any false information on my application may subject my certification to disciplinary action pursuant to the Kentucky Certified Athletic Trainer Statutes and Regulations.

_____

Signature of Applicant **Date**

Subscribed and sworn before me by the above named applicant this

_____day of _____, _____

This application consists of 3 pages.

_____

Signature of Notary

My commission expires: _____

Seal of Notary

*This Application is in compliance with the American Disabilities Act

(Revised 8/18/99, 8/17/00, 1/07/02, 11/13/02, 10/7/03)

Name _____ *Social Security Number* _____

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and (I) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board (KBML) and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a certification decision based upon them.

"Illegal drug use" means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

1. Do you currently, or have you had within the past 5 years, any physical, mental, or emotional condition which impaired, or might reasonably impair your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
2. Within the past 5 years, have you been admitted to any hospital or other in-patient care facility for any physical, mental or emotional condition which impaired, or might reasonably be considered to impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
3. Do you currently have, or have you had within the past 5 years, a dependency on or abuse of the use of alcohol or drugs, which impaired, or might reasonably impair, your ability to practice your health care profession safely and competently?
   ☐Yes ☐No
4. Within the past 5 years, have you engaged in the excessive use of alcohol or illegal drugs, or received any in-patient or outpatient or individual therapy/treatment or been hospitalized for alcoholism, or illegal use, or been arrested for a DUI (Driving Under The Influence)?
   ☐Yes ☐No
5. Within the past 5 years, have you been the subject of any chemical substance screening test which resulted in an indication of the presence in your body of any controlled substance, any dangerous drug, or alcohol level above .10% BAC? (This does not include those drugs taken by you as a result of a legitimate health care diagnosis, and prescribed for you in good faith by another licensed health care professional.)
   ☐Yes ☐No

*****Affidavit of Applicant*****

I hereby state that the information contained in this application is true, accurate, and complete to the best of my knowledge and belief. I understand that under Kentucky law the submission of any false, fraudulent or forged statement, document or other matter in connection with this application is grounds for criminal prosecution and the denial of certification. I authorize the Board (KBML) or its agents to obtain from other sources any information necessary for determining my qualifications for certification. I also authorize them to furnish any information they may now or in the future have concerning my qualifications and fitness to practice as an athletic trainer to any person, institution, association, school, hospital or government entity.

_____

(Signature of Applicant)

_____

(Print Name)

Subscribed and sworn to before me by the above named applicant this _____day of _____
(month, year)

_____

(Signature of Notary)

Seal of Notary

My commission expires: _____

• • • DEADLINES FOR COUNCIL MEETING DATES • • •

In order for your application to be presented to the State Advisory Council on Athletic Trainers, your application must be completed in its entirety and must be on file in the Board office no later than the deadline dates listed below. Once the Council reviews your application, it will be presented to the Kentucky Board of Medical Licensure for final approval.

Deadline Date	AT Meeting Date	Board Meeting Date
January 16, 2004	February 4, 2004	March 18, 2004
April 16, 2004	May 5, 2004	June 17, 2004
July 16, 2004	August 4, 2004	September 16, 2004
October 15, 2004	November 3, 2004	December 16, 2004

ATHLETIC TRAINER

REQUEST FOR TEMPORARY CERTIFICATE

If you need to begin working as a certified athletic trainer in the Commonwealth of Kentucky before the next Board meeting, you may request a temporary certificate. Once your application is complete, a copy of all your documentation will be forwarded to the Chairman of the State Advisory Council on Athletic Trainers for consideration for a temporary certificate. Upon approval, a temporary certificate will be issued**. Please be advised that there is an <u>additional</u> $25.00 fee for a temporary certificate.** (There is also a $25.00 fee for full certification.)

If you wish to request a temporary certificate, please complete the following:

NAME: _____

Employment Location: _____

Address: _____

_____

Phone Number: _____

FORM 1

National Athletic Trainers' Association
Waiver Release Form

Applicant: Complete the top portion of this form and attach a **$15.00 processing fee** payable to the NATA. Please send completed form to: NATA, 4223 South 143rd Circle, Omaha, NE 68137.

NAME:_____

ADDRESS:_____

_____

NATA Certification #:_____

_____
Applicant Signature

I authorize the National Athletic Trainers Association to release to the Kentucky Board of Medical Licensure all of the information requested below.

- - - - - - - - - - - - - - - - - - -

VERIFICATION OF NATABOC CERTIFICATION

As Executive Director of the National Board of Certification, Inc., Continuing Education Office, I hereby attest that the above named applicant has successfully passed the National Athletic Trainers' Examination and has been assigned the following:

Name: _____

NATABOC Certification Number: _____

Certification Date: _____

Expiration Date: _____

Certification in Good Standing? _____ Yes _____ No

*If the answer is **"No"** to the above question, please provide additional information.*

_____ _____
NATABOC Signature Date

Please mail form directly to: Kentucky Board of Medical Licensure
Attn: Sandy K. Brooks, Athletic Trainer Coordinator
310 Whittington Pkwy., Suite 1B
Louisville, KY 40222

FORM 2

Verification of Athletic Trainer Training Hours

Applicant: Please complete this section of the form and mail entire form to athletic training supervisor with whom you completed your training hours under. If needed, you may copy this form for additional copies.

As a part of the application for certification as an athletic trainer, the Kentucky Board of Medical Licensure requires this form be completed by each athletic training supervisor where I performed internship hours. I, hereby authorize the release of any information in your files, favorable or otherwise, to be **sent directly to the Kentucky Board of Medical Licensure, Attn: Sandy K. Brooks, Athletic Trainer Coordinator, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222**

Applicant's Name:_____

Address:_____

_____

Do Not Detach

- -

Name of Student:_____

_____
Organization/University where completed Training Hours:

_____
Address of Organization/University

Date began training:_____ Date completed training:_____

Total Number of Hours Completed: _____

Sports/Activities student participated in training _____

_____

Athletic Training Supervisor: _____

Title:_____

Signature: _____

Form 3

Verification of Certification
Athletic Trainer

Applicant: Please complete this section of the form and mail to each state board in which you are now or have ever been certified/licensed, as an athletic trainer. If needed, you may copy this form for additional copies.

As a part of the application for certification as an athletic trainer, the Kentucky Board of Medical Licensure requires this form to be completed by each state in which I hold or have ever held certification. I, hereby, authorize the release of any information in your files, favorable or otherwise, to be **sent directly to the Kentucky Board of Medical Licensure, Attn: Sandy K. Brooks, Athletic Trainer Coordinator, 310 Whittington Parkway, Suite 1B, Louisville, KY 40222**

_____, A.T.C.
(Signature)

Name: _____

Address: _____

_____

Certificate Number: _____

- -

State of:_____ Certificate/License No.:_____

Issue Date: _____

Full name of Certificate holder:_____

By: _____ NATA examination? _____ State Board's Written Exam?

Is Certificate current? _____ If "**NO**", why not?_____

_____

Has certificate been subject to disciplinary action by your agency?_____

If **"Yes",** please provide additional information.

Comments, if any, _____

Signed: _____

Board Seal Title: _____

Date: _____

KENTUCKY BOARD OF MEDICAL LICENSURE

HIV/AIDS Education Documentation Requirements

During the 1990 regular legislative session, the General Assembly passed House Bill 425, which mandated Human Immunodefiency Virus (HIV) and Acquired Immunodefiency Syndrome (AIDS) education requirements for health professionals. Further, the General Assembly mandated that the Cabinet for Health Services (CHS) administer this program and that the Kentucky Board of Medical Licensure monitor compliance.

On or after September 24, 1991, all applicants for certification as an athletic trainer must comply with the two (2) hour HIV/AIDS education requirement.

Prior to receiving current certification, each applicant for certification MUST submit to the Kentucky Board of Medical Licensure ONE of the following:

1. A copy of a certificate of completion of an approved course. The HIV/AIDS course (2 hours minimum) must be included on the official listing of approved courses maintained by CHS, and the CHS course approval number must appear on the certificate.

2. An "Affidavit of Reasonable Cause" form if the requirement is not met prior to certification. If the HIV/AIDS course has not been completed, the applicant may complete an "Affidavit of Reasonable Cause" form to verify that the requirement will be met within the next six (6) months. This affidavit shall be valid for no more than six (6) months and is **not renewable**. Eligible applicants will be issued a Temporary Certification only for a six month period. ***The full certification to function as an athletic trainer in Kentucky will NOT be issued until this requirement has been met.***

If you have any questions regarding applicable courses, approval or courses, or if you need to obtain a listing of approved courses, please contact:

AIDS Education Program
Cabinet for Health Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6539
http://chs.ky.gov/publichealth/hiv-aids.htm

* * Home Study Courses Are Available! * *

Kentucky

HIV/AIDS Education

AFFIDAVIT OF REASONABLE CAUSE

I, _____ request that the Board of Medical Licensure defer my HIV/AIDS education requirement for initial professional certification for the following reason: (Please explain in detail)

_____

_____

_____

I understand that the deferment is valid for a maximum of six (6) months from the date of the issuance of a temporary certificate to practice as an athletic trainer, or approval by the Board for full certification. I also understand that this is not renewable. I further understand that within six months I must send to the Kentucky Board a copy of a certificate showing completion of an HIV/AIDS course that has been approved by the Kentucky Cabinet for Health Services.

Signature: _____ Date: _____

Printed Name: _____

Social Security Number: _____

***NOTE**: This form must be sent to your Kentucky Board in order for you to receive a six month extension. Please retain a copy of this affidavit for your records.

MAIL TO THE KENTUCKY BOARD AT THE ADDRESS BELOW:

Sandy K. Brooks
Kentucky Board of Medical Licensure
The Hurstbourne Office Park
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
(502) 429-8046

Kentucky HIV/AIDS Education Program
Department for Health Services
Cabinet for Health Services
275 E. Main Street
Frankfort, KY 40621-0001
(502) 564-6539

You may order a list of approved HIV/AIDS education courses from the Kentucky Cabinet for Health Services by completing the form below and mailing to the Cabinet for Health Services or by visiting the Cabinet's website. The website address is: http://chs.ky.gov/publichealth/hiv-aids.htm

Send me the list(s) of:

_____ Home study courses only
(These are correspondence courses.)

_____ Lecture courses only

_____ Home study and lecture courses

Send this request to (<u>please print or type</u>):

Name: _____

Address: _____
Street

_____
City State Zip

Daytime Phone #: _____

MAIL THIS FORM TO ADDRESS AT TOP OF PAGE

Revised (1/03/02)